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Sustain, Maintain, or Transform?

I just got back from our September Leadership Conference and Governance Support Forum at The Broadmoor in Colorado Springs. The energy flow between people, spaces, and ideas was at a level I have not felt in a long time. There were a lot of difficult topics to cover given today's healthcare landscape, but also a great degree of excitement and hope for the future.

A theme that arose is that boards need a fuller picture of what is happening in their regional markets against how the organization is *really* doing, now, in the short term, and in the longer term. The call is for board members to develop their own perspectives on important challenges facing the organization, and look at it from the outside in.

The main takeaway I want to challenge our boards with is this: too many boards are having the same kinds of discussions in the boardroom. They are looking at strategic plans that look very similar to their plans pre-COVID, and selecting from the same strategic options being presented by management. If you need a "ground zero" for where you should start making changes, I believe it is here.

Kathryn C. Peisert,
Editor in Chief & Senior Director

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LEADERSHIP CONFERENCE
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Please note: Conference expenses paid for by a board member can be claimed as a donation and listed as an itemized deduction on the board member's income tax return. Please consult your tax advisor for more information.

Grounding the Board in the Complex Work of Caregiving

By Kathleen Silard, M.S., B.S.N., RN, FACHE, Stamford Health

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I became the President and CEO of Stamford Health, an independent, non-profit healthcare system in Fairfield County, CT in 2018. At that time, we had recently built a brand-new, beautiful 305-bed hospital and we had plans to significantly grow our ambulatory network and medical group. At the same time, we were challenged with a burdensome state tax and needed to make significant technology upgrades, namely a new electronic health record. Non-profit and especially independent healthcare systems, like Stamford Health, need a strong, invested board to thrive, and this was an important area of focus for me as our new President and CEO.

Kathleen Silard, M.S., B.S.N., RN, FACHE
President and CEO
Stamford Health

Stamford Health is governed by a board of directors made up of 15 individuals from diverse backgrounds who are thoughtfully selected and include patients, physicians, business leaders, and engaged community members. Our board members, like every board, play a pivotal role, as they are tasked with overseeing the mission and strategic direction of our organization and as stewards for the organization in the community. Healthcare is a complex, intricate system and our board members serve the organization best when we proactively connect them with our work, which we accomplish through a multi-pronged approach.

Invest in Onboarding

First, we ensure each new board member is onboarded comprehensively, to align them with the organization's mission and operations. Orientation sessions cover topics like governance structures and legal responsibilities but also delve into the history, culture, and strategic priorities of the system. Each board member's first committee assignment is with the quality and clinical affairs committee to give them visibility to the work we do.

Create Opportunities for Exposure

Throughout each board member's tenure, they receive periodic tours of the organization. These firsthand encounters allow board members to witness clinical care, interact with staff, and observe the delivery of services directly. By spending time in different departments, from emergency rooms to the Cancer Center, board members gain a nuanced understanding of the challenges and successes faced by frontline workers. This immersion helps board members understand the context within which decisions are made and fosters a sense of commitment to the organization's mission.

Provide Continuous Education

After initial onboarding, continuous education opportunities are embedded into our board programming. These sessions keep board members informed about emerging healthcare trends, regulatory changes, and advancements in medical technology. Regular workshops, seminars, and briefings ensure that board members remain knowledgeable and proactive in their governance role. A recent education session focused on how we can use AI technology through our electronic health record to support caregivers and free up time spent on documentation and notes. We have also held education sessions about innovation within our system including a tour of our Simulation Lab and lectures on advancements in breast imaging, robotic joint replacement, advanced thoracic diagnostic modalities, and value-based care.

Reinforce the Mission

Finally, we remind board members of the organization's mission and impact on the community regularly to reinforce their commitment and sense of purpose.

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››› KEY BOARD TAKEAWAYS

To effectively fulfill their duties, it is essential that board members have a deep and meaningful connection with the day-to-day operations and mission of the organization. Ways to strengthen this connection include:

- **Invest in onboarding:** Ensure new board members are onboarded comprehensively to align them with the organization's mission and operations.
- **Create opportunities for exposure:** Allow board members to witness clinical care, interact with staff, and observe the delivery of services directly to help them understand the context within which decisions are made and foster a sense of commitment.
- **Provide continuous education:** Keep board members informed about emerging healthcare trends, regulatory changes, and advancements in medical technology so that they remain knowledgeable and proactive in their governance role.
- **Reinforce the mission:** Tell stories, commemorate milestones, and recognize the contributions of staff that underscore the tangible outcomes of the board's decisions and celebrate a shared sense of pride in the organization's mission-driven work.

ORGANIZATION PROFILE

Stamford Health is an independent, non-profit health system comprised of a 305-bed acute care hospital, a growing ambulatory network including four multispecialty centers and a medical group with more than 200 physicians and advanced practice providers in 40 offices throughout Fairfield County, Connecticut. With more than 3,800 employees, Stamford Health is the largest employer in the City of Stamford, has an operating budget of close to $1 billion, and contributes more than $1 billion a year to the local economy.

"Healthcare is a complex, intricate system and our board members serve the organization best when we proactively connect them with our work."
—Kathleen Silard, M.S., B.S.N., RN, FACHE

Fear Not the Executive Session

By David C. Pate, M.D.

In my private conversations with fellow CEOs regarding governance issues, almost every leader told me that they intensely dislike executive sessions of the board; more specifically, they dislike being excused from those sessions. I believe that this near-universal sentiment (in my experience) is misguided.

CEOs may or may not also be directors of their organization's board. If they are members of the board, then they would generally be included in the executive session. However, even if they are board members, it is appropriate, at times, to excuse the CEO from the executive session.

This article highlights the benefits of well-run executive sessions, reasons for periodically excusing the CEO, and encourages boards and CEOs to welcome (rather than fear) this opportunity for additional feedback and discussion.

Why Are Executive Sessions a Good Governance Practice?[1]

Board members, especially newer ones, have often told me they are reluctant to openly challenge staff about issues in which they have little expertise, to ask questions in front of management that might be considered "dumb" or unsupportive, or to take up time with their questions, especially when time on the agenda is coming to an end. During my tenure as a health system CEO, I found executive sessions to be an excellent time for board members to ask me these questions or express their concerns in an environment where they may feel more at ease. Often, the questions they were unsure about asking ended up generating robust discussion among me and the board, and revealed that other board members had similar questions.

The executive session provides an opportunity for the CEO to solicit helpful feedback from the board as well. For example:

- Are we covering the right topics in our board meetings?
- Are there important topics that are not on the board calendar?
- Are we effectively preparing the board for the educational and strategic topics discussed at board meetings? For instance, are the right amount and kind of materials included in board books?
- Are staff presentations the right level of detail to prompt an informed discussion among board members as opposed to just repeating the same information that was already covered in the board book?
- Are we allowing enough time for board discussion?

These and other questions will generate better input from the board when discussed in private with the CEO and lead to improved meetings in the future.

Board agendas usually are full and leave little time for discussion of current events, market developments, and other topics of interest and concern to board members. Executive sessions can be an excellent opportunity for board members to raise these issues and ask questions. In many cases, the CEO can address those questions at that time. However, on occasion, board members will surface an issue that has very important and broad-reaching implications that may warrant a staff presentation at the next board meeting.

My parents taught me a lesson that served me well in life. They told me, "David, if there is bad news, we had better hear it from you before we hear it from someone else." As CEO, I made that lesson the expectation among my team, and in turn, strived to ensure that the board heard any bad news from me before they heard it from someone else or read about it in the papers. The downside is that the CEO may end up disclosing some potentially bad news that never materializes, but, in my experience, the gain in trust of the board more than makes up for this. During executive sessions the CEO also has a chance to expand on these issues and provide follow-up on leadership's progress in avoiding, mitigating, or dealing with the bad news.

Why Excuse the CEO?

Of course, we all know that the CEO should not be present when the board is reviewing the CEO's performance or compensation. But there are other less common situations, such as when the board needs to review a complaint about the CEO or consider a business undertaking that may cause a conflict of interest for the CEO.

Just as employees should not be surprised by the findings of their appraisal at annual performance evaluations, neither should the CEO. Periodically excusing the CEO for the last 10–15 minutes of the executive session permits the board chair to inquire whether board members have concerns or suggestions for the CEO's performance.

››› KEY BOARD TAKEAWAYS

- **Embrace the advantages of executive sessions.** Executive sessions allow for open communication between the board and CEO outside of regular meeting time. This is an opportunity to have honest conversations, voice concerns, ask questions, and provide feedback.
- **Excuse the CEO when needed.** There are certain situations where the CEO shouldn't be present for a portion of the meeting (e.g., when discussing CEO performance or compensation or if the CEO has a conflict). The important thing is to have clear communication around what the discussion will be about and exactly why the CEO is being excused.
- **Utilize this time for constructive feedback.** Executive sessions are the right time for board members to provide ongoing feedback to the CEO through the board chair. This ensures the CEO knows how the board perceives his/her performance and allows the CEO a chance to use the board's suggestions to course correct.
- **Build a trusting CEO–board chair relationship.** Set up a regular meeting between the chair and CEO after board meetings to review the outcomes of the meeting, plan for the next, and discuss any feedback and suggestions for the CEO.

Reasons Not to Fear These Sessions

It is in the best interests of the board for the CEO to be successful. Boards invest a lot of time, emotional energy, and organizational resources into recruiting, selecting, and hiring their CEOs. When the CEO doesn't work out, it is an embarrassment for the board, disruptive to the organization, often a public and media relations challenge, costly, and a bit of a black eye that may cause qualified applicants reluctance to enter a search with the organization.

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1 This is not intended to be an exhaustive list. There are many articles that provide a deeper dive on this topic. For example, see Larry Gage and Lawrence Prybil, "Guidelines for Effective Board Executive Sessions," *BoardRoom Press*, The Governance Institute, June 2022.

Healthcare Transformation in the COVID Era: The Governance Institute's One Impact Initiative

Special Commentary by Kevin Barnett, Dr.P.H., M.P.H., M.C.P.,
Center to Advance Community Health & Equity and Public Health Institute

Overview

After three decades of engagement with hospitals, health systems, and diverse stakeholders to develop comprehensive strategies to address the drivers of poor health, it is clear to me that the healthcare sector is at a major crossroads. For hospitals, historically focused on the delivery of acute-care services, what progress can we claim in the strategic allocation of resources and partnerships with diverse stakeholders to improve health and well-being in communities? Despite the potential benefits of investment in comprehensive interventions to reduce the demand for increasingly high-cost clinical treatment, is such diversification desirable and/or an appropriate role for hospitals and health systems?

One of the many ironies of the COVID pandemic is that it highlighted the profound health inequities in geographically defined communities, *and* it has eroded the capacity of our hospitals to play an important role in addressing them. In numerous conversations over the past two years with senior leaders of hospitals and health systems, colleagues have cited a deeper awareness of the profound disproportionate negative effects on the residents in their most socio-economically challenged communities. The high COVID incidence and mortality in these communities illuminates the powerful impact of social and physical environmental factors at the individual, family, and community levels. At the same time, despite substantial allocations of COVID-related funding from federal and state agencies, hospitals face some of the most significant financial challenges in their history. In response, many are scaling back on proactive investments in community health.

The Governance Institute, with the support of the Center to Advance Community Health and Equity (CACHE) at the Public Health Institute, launched the One Impact initiative in early 2022, just as the healthcare industry was grappling with the full financial impacts of COVID, as well as its disproportionate impact on communities at the lower end of the socio-economic spectrum. Our initial intent with the initiative was to document the evolution over four decades of hospital and health system engagement in efforts to address the social determinants of health (SDOH), now reframed and supported across federal agencies as Vital Conditions.[1]

One of the goals was to move beyond documentation of "one-off" case examples to better understand how organizations were measuring their impacts and fostering institutional alignment and accountability. This required a more systematic collection of data across institutions to build a better understanding of common conditions, principles, and policies (both institutional and public) necessary for near-term success and long-term sustainability. Of central importance, the intent was to provide a structural framework and to better describe what inspired leadership looks like, both among executive leaders and governing boards. Finally, the intent was to help identify what is needed in the policy arena at the local, state, and federal levels to build health and well-being in a more equitable manner in communities across the country.

For obvious reasons, the COVID pandemic required a pivot in strategy. It became clear that our hospitals and health systems were necessarily focused on addressing the catastrophic conditions in their communities and keeping their doors open in almost impossible circumstances. There was no question of collecting data at scale, nor was it realistic to engage leaders on broader issues.

KEY BOARD TAKEAWAYS

For our One Impact initiative, insights were shared by a variety of colleagues who observed a downscaling of investments in addressing the drivers of poor health, as well as the elimination of leadership positions responsible as part of a strategy to stem financial losses. Here are some issues for boards to consider as they move forward:

- What barriers do we need to remove as an organization and leadership team to proactively address health inequities in the communities we serve?
- How can we better integrate these efforts into the work we are already doing with the staff and resources that we currently have?
- What partnerships can we leverage with local institutions and agencies across sectors to do this work at scale?
- How can we shape our community investments in ways that will produce measurable improvements and lay the groundwork for local policy development?
- What education, advocacy, and action is needed to make the case in the public policy arena to incentivize investments by hospitals that reduce the demand for high-cost clinical treatment of preventable conditions?

> *After three decades of engagement with hospitals, health systems, and diverse stakeholders to develop comprehensive strategies to address the drivers of poor health, it is clear to me that the healthcare sector is at a major crossroads.*

1 See Community Commons, "Seven Vital Conditions for Health and Well-Being."

Thus, for our One Impact initiative, we needed to shift the focus from a broader, quantitative survey across the sector to a set of in-depth, qualitative interviews with executive leaders. We wanted to reflect on the impacts of the pandemic and explore the implications for hospitals returning to a focus on proactively addressing health inequities in their communities in a more strategic, integrated manner that has greater potential to result in broader and more sustainable results. Insights were shared by a variety of colleagues who observed a downscaling of investments in addressing the drivers of poor health, as well as the elimination of system leadership positions responsible as part of a strategy to stem financial losses.

We wanted to explore the implications for hospitals returning to a focus on proactively addressing health inequities in their communities in a more strategic, integrated manner that has greater potential to result in broader and more sustainable results. Colleagues observed a downscaling of investments in addressing the drivers of poor health, as well as the elimination of system leadership positions responsible as part of a strategy to stem financial losses.

Challenges and Key Drivers

There are multiple drivers behind the current financial challenges faced by hospitals, including, but not limited to a dramatic loss of workforce; exacerbating shortages that existed prior to the pandemic; continuing escalation of costs for labor, equipment, and pharmaceuticals; continuing downward pressure on reimbursement; monopolistic behavior by commercial health plans; and a failure of state and federal agencies to move forward with risk-based payment structures that reinforce and reward strategic investments in prevention. On the prevention front, non-profit hospitals are confronted with disincentives from both payers and the IRS; the former due to a reluctance to engage in shared-risk payment arrangements, and the latter due to a bias towards traditional charity care and against primary prevention interventions.[2]

Just as the COVID pandemic has emphasized the inequities in our communities, it has also highlighted the parallel inequities in our regional healthcare markets. In most urban areas with two or more competing hospitals, there is typically one institution that is in a dominant market position, and it has been in that position for many years. In many cases, it is a large teaching facility. Because of its dominance, it is in an advantageous position to negotiate higher rates with payers, which helps to keep faculty salaries competitive.

Hospitals that are second or third in the regional market often have a less favorable payer mix and higher percentages of public pay patients, in part because they are more proximal to lower-income communities. Because these hospitals have more low-income patients on Medicaid who arrive each day in their emergency departments, they have less discretionary dollars to strategically invest in prevention interventions.

Of equal importance, the second- and third-place hospitals face obstacles with payers in negotiating competitive rates or shared-risk arrangements. While the Disproportionate Share (DSH) Medicaid program has eased some of the immediate burden for hospitals that are most impacted, limits to the reimbursement rates and higher acuity among the patient populations erodes their financial stability over time. The net result is ever increasing expenditures for acute-care medical services, and fewer dollars available (both from the public and private sectors) for more strategic investment in building healthier communities.

Recent trends are particularly concerning, with the accelerating acquisition of medical practices by private equity firms[3] showing a seven-fold increase in the last 10 years, and now exceeding 50 percent of market share in over 50 MSA markets. Acquisition of provider practices and various forms of specialty care have a net effect of removing components of hospital functions with higher returns on investment, leaving higher-cost, low-return functions, and for those with less favorable payer mixes, increasing financial pressure. For example, one health system we spoke to has experienced private equity funding of

outpatient clinics in the market that have diverted significant volumes of profitable services away from the health system.

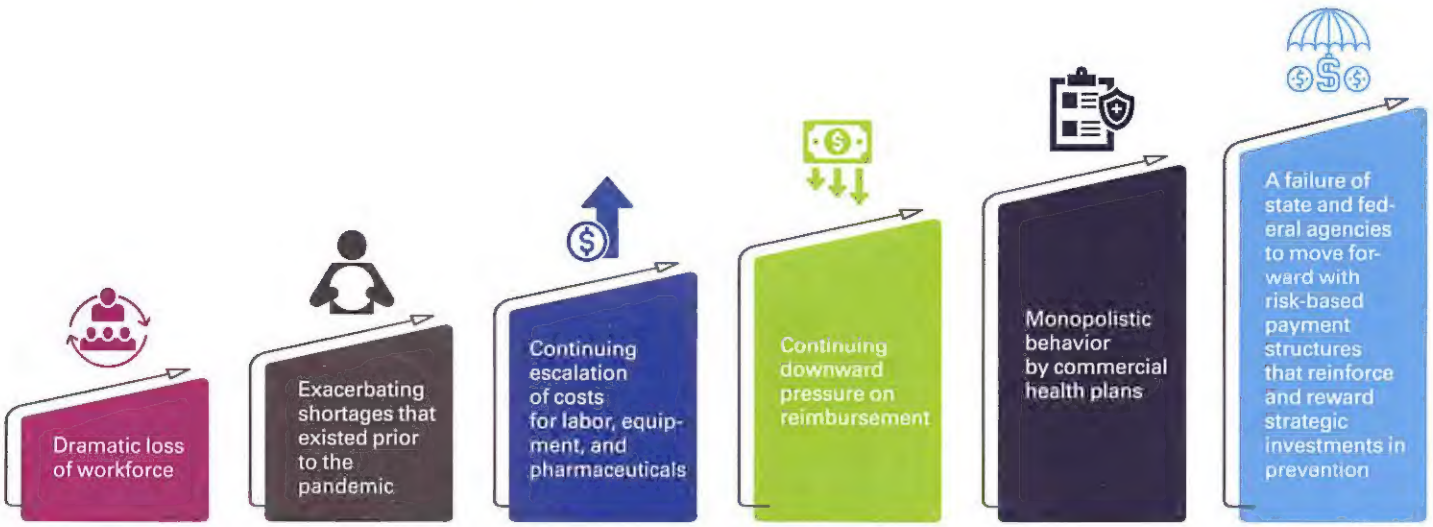
Many non-profit hospitals in urban inner cities have closed in recent decades due to the impact of long-term financial declines resulting in deteriorating infrastructure, loss of providers, and higher percentages of Medicaid, underinsured, and uninsured patients. Market dynamics are equally challenging for rural hospitals across the country, particularly in states that have still resisted the Medicaid expansion. Closures are accelerating, driven most significantly by the inability to negotiate reimbursement rates with payers that are sufficient to keep their doors open.

Community Health and Professionalism

It is worthwhile to reflect on the progress made by hospitals in building capacity to address the drivers of poor health in

2 Among primary prevention activities, "community building" was proposed as a category of community benefit programming in a 1997 monograph entitled "The Future of Community Benefit," and was integrated into the Catholic Health Association's Social Accountability Budget. It included actions to improve the quality of housing, increase access to affordable healthy foods, and other related activities, but was rejected as a financially reportable category by the IRS in their Revised Form 990 in 2010. Stated objections by internal IRS staff included a concern that non-profit hospitals could use the category to gentrify proximal neighborhoods; a concern that could have easily been addressed with clear guidelines and periodic reviews.

3 Ola Abdelhadi, et al., "Private Equity-Acquired Physician Practices and Market Penetration Increased Substantially, 2012–2021," *Health Affairs*, Vol. 23, No. 3, March 2024.



local communities. This work has been led primarily, though not exclusively, by the non-profit hospital sector as a function of their fulfillment of their charitable obligations.

An underlying ethic for these institutions is a commitment to optimal stewardship of their charitable resources. Stewardship in this context translates into resources and strategies that proactively improve health and well-being and reduce the demand for high-cost treatment of preventable conditions. Building capacity to be good stewards requires investments in a workforce with the required expertise and establishing accountability to produce desired results.

Over the last four decades, we have seen a steady increase in hospital engagement in community health improvement, driven in part by professionalization at the staff level, and increased accountability at the senior leadership level. Multi-state initiatives such as the Advancing the State of the Art in Community Benefit (ASACB) demonstration[4] established a set of standards for hospitals and systems, including core principles that emphasized primary prevention and a focus in communities where health inequities are concentrated.

It also moved oversight (in many cases) from marketing departments to executive leadership, often with vice presidents or senior vice presidents of population health or related functions, and established performance metrics at the CEO level for review by governing bodies. At the staff level, given a high rate of turnover driven in part by a lack of clarity about the scope of responsibilities, standard job descriptions, each with an associated percentage of FTE, helped educate and illuminate what was needed to ensure excellence in function.

A key challenge in advancing practices in community health has been to effectively integrate timely patient care navigation, helping people connect with organizations to meet their social needs, and implementing place-based strategies to address drivers of poor health. While progress has been made, among the most significant obstacles is our fitful and uneven movement at the federal policy level towards risk-based payment.

It is startling that after decades of promises, encouragement, and threats, fee-for-service is still the dominant form of payment, with the exception of a few states (e.g., MD, OR, MN). The net effect is that hospitals are in a bind as it relates to upstream investments. If they are effective in reducing preventable admissions at scale, for example, by implementing comprehensive strategies to reduce hospitalizations for diabetes, the result is a reduction in revenue.

Rebuilding Public Trust

The "honeymoon" of public appreciation for hospitals during the COVID pandemic was a short one, and it has been replaced by a plethora of bad news (and selective bad behavior) that largely erased public goodwill. It doesn't matter that the bad institutional behavior is the exception rather than the rule; the continuing escalation in healthcare costs, excessive compensation of executive leaders, accrual of medical debt among nearly half of the adult population, facility closures in low-income communities, and growing challenges to timely access are being laid at the feet of our hospitals. It isn't fair, but here we are.

While progress has been made, among the most significant obstacles is our fitful and uneven movement at the federal policy level towards risk-based payment. It is startling that after decades of promises, encouragement, and threats, fee-for-service is still the dominant form of payment.

Data from The Governance Institute's 2023 Biennial Survey[5] shows a stark decline in activity at the board and senior leadership level in this work, along with a decline in performance of the core responsibility of community benefit and advocacy, an area that has historically ranked last for boards, both in performance and adoption of recommended practices. We see this as a lack of board and leadership understanding about the central importance of community health to the role, mission, and ultimately success of non-profit hospitals and health systems.

This trend is extremely concerning, as much of this work is required to

4 ASACB was implemented by the Public Health Institute between 2002 and 2006, with braided funding from multiple national, state, and regional foundations, and participation of 75 hospitals in CA, TX, AZ, and NV.

5 Kathryn Peisert and Kayla Wagner, *Think Bold: Looking Forward with a Fresh Governance Mindset,* Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute, 2023.

enable organizations to transform their delivery system away from a focus on inpatient, acute care. Outside disruptors are continuing to make the job of providing integrated care at the right settings for the right costs more and more difficult for legacy health systems. While general survey data for the field highlights a lack of board and senior management leadership about the central role of community health in the current environment, it is not universal.

As compellingly articulated by Michael Sandel in his recent book,[6] our cultural values of small government, hyper-indi

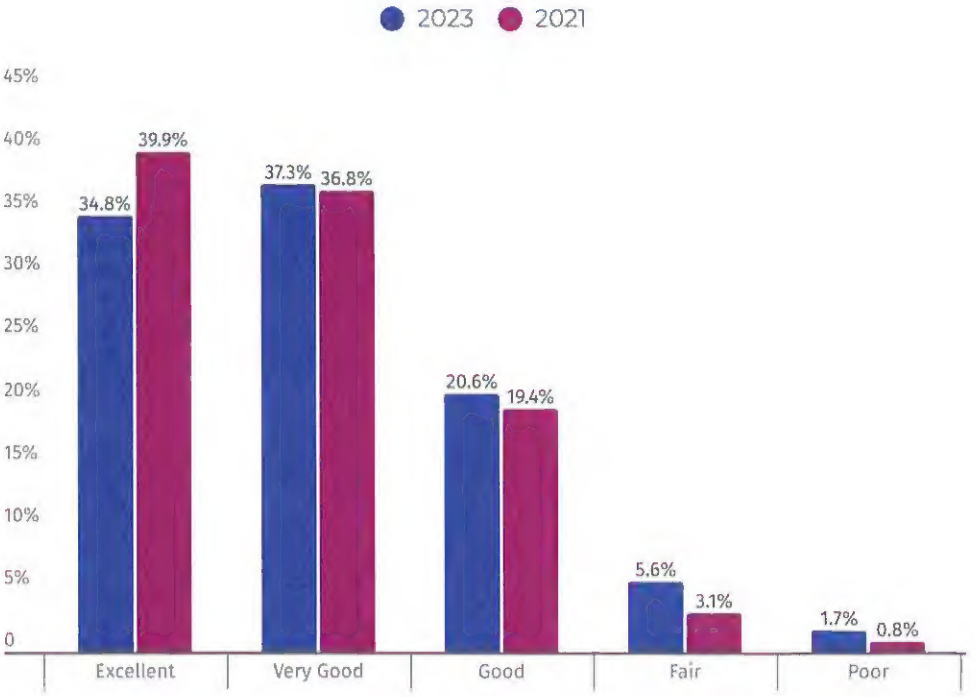
One of the silver linings of the COVID pandemic was the establishment of new working relationships between hospitals and a variety of related organizations, ranging from local public health agencies and federally qualified health centers to community development organizations, advocacy organizations, educational and religious institutions, and local elected officials. In many cases, these new relationships have illuminated new ways in which to more effectively and proactively address health needs and build civic capacity.

health is inappropriate.[7] It is certainly the case that one approach to healthcare delivery in the future is to narrow, rather than expand, the scope of interventions by hospitals. Such a scenario would likely further limit both the scope of services provided by hospitals and their negotiating leverage with payers, among a range of other outcomes.

The alternative scenario is one of increasing integration within and across sectors. One of the silver linings of the COVID pandemic was the establishment of new working relationships between hospitals and a variety of related organizations, ranging from local public health agencies and federally qualified health centers to community development organizations, advocacy organizations, educational and religious institutions, and local elected officials. In many cases, these new relationships have illuminated new ways in which to more effectively and proactively address health needs *and* build civic capacity.

In the coming months, we will share examples of positive deviant stories where boards and senior leaders have helped to accelerate decisions, launch initiatives, allocate resources, and engage in targeted advocacy that focuses on addressing inequities and improving vital conditions in our communities—despite the many COVID and unrelated challenges. We will share profile perspectives from executive leaders as well as emerging practices from forward-thinking (and acting) governing bodies. On this difficult and illuminating journey, we have heard from so many people experiencing firsthand the pausing or shrinking of these efforts both due to COVID. Now that we have entered the post-COVID era, we will share the thinking of leaders on how to leverage what we have learned to work more cooperatively with diverse stakeholders to redefine and elevate the role of hospitals and health systems in America.

Evaluate your board's overall performance in fulfilling its responsibility for community benefit and advocacy.



Source: The Governance Institute's Biennial Survey of Hospitals and Healthcare Systems.

TGI thanks Kevin Barnett, Dr.P.H., M.P.H., M.C.P., Executive Director, Center to Advance Community Health & Equity and Principal Investigator, Public Health Institute, for contributing this special commentary. He can be reached at kbarnett@thecachecenter.org.

6 Michael Sandel, *The Tyranny of Merit: Can We Find the Common Good?,* Penguin Books Limited, 2020.
7 Chris Pope, "Is Everything Health Care? The Overblown Social Determinants of Health," Manhattan Institute, July 2024.

Positioning Your Health System for a New Future

By Dave Morlock, Cain Brothers

We are in the midst of an interesting time for the healthcare industry. For several years, health systems have been experiencing a slow and steady shift in the key basic business model including:

- Care moving from the inpatient setting to the outpatient and home settings
- An increase of government paid business as a percentage of the payer mix
- A shift from traditional Medicare to Medicare Advantage
- Public and private equity investment in care delivery

These changes have led to downward pressure on revenues and cash flows, and what feels like a never-ending cycle of budget cuts every year.

More recently, the pandemic was a catalyzing moment for the industry. It forced us to deal with significant upward pressure on expenses driven by inflation, supply chain issues, rising interest rates, organized labor momentum, burnout, and relative labor force contraction.

From a business model perspective, this all suggests that we are reaching (or have reached) a tipping point.

The interesting element in all of this is the significant bifurcation of health systems during this turmoil. Almost half of all hospitals are losing money. Another quarter are making money, but not enough to keep up with capital expenditure needs. This manifests itself in layoffs, bond rating downgrades, large multi-market systems selling off hospitals, and one of the largest health system bankruptcies in history.

On the other hand, a quarter of hospitals are doing very well financially. The performance of some large health systems has soared in the last year, despite hundreds of other hospitals that are at risk of closure. Many large health systems with scale, regional density, and strong strategic direction are thriving. This includes academic health systems, too. These large systems are building balance sheets that give them a margin of error, as well as the opportunity to pursue acquisitions, growth strategies, and invest in the ambulatory and value-based care spaces.

Conversely, smaller systems often have weakened balance sheets with virtually no margin for error or ability to weather additional head winds beyond their control. This means that they are not positioned to invest heavily in new strategic directions.

Steps for Senior Leadership and the Board

In our advisory work around the country, we are continually asked by boards and CEOs "What should we do?" While there is not a one-size-fits-all path, it is important to take the following steps to position your health system for the future:

- Invest in ambulatory care with lower cost settings (let go of your reliance on the hospital outpatient department).
- Invest in physicians and physician relationships.
- Invest in technology that supports managing risk, value-based care, consumerism, and supporting physicians.
- Invest in "economies of capability" rather than just economies of scale.
- Seek M&A and joint venture opportunities that support growth in the ambulatory care space.
- Have significant insight into the actual cost of the various services that your organization provides.
- Tap alternate sources of capital that go beyond the traditional sources of capital.

All of these elements require access to capital and scale. Your health system must be a relevant participant in a relevant market. You also need density in your region, and that region must be large enough to support the necessary scaled growth to facilitate these investments. Regions are now measured statewide and across state lines. It is no longer enough to be a dominant player in a mid-sized town and the surrounding county. Regions are getting bigger.

An exception to this approach exists if your health system is located in one of the fastest-growing large metro areas in the country. In that case, sheer volume growth will permit you to ride the old fee-for-service business model a bit longer. But even then, that strategy's success will be measured in years rather than decades.

The underlying business model of health systems has been changing for years, and the change is accelerating. Very large health systems with broad regional density are positioned well for the changes. But smaller health systems are at risk of not being able to invest in the necessary elements to ensure future success. Seeking alternate capital, M&A opportunities, and partnerships is a must in order to survive well into the future.

>>> KEY BOARD TAKEAWAYS

- Which side of the bifurcation is your health system on—strong long-term survivor or struggling to get by?
- Does your organization have the scale, regional density, and strong strategic direction to survive?
- Does your health system have any margin of error if additional headwinds emerge?
- What necessary investments is the organization making in ambulatory care, physicians, technology, joint ventures, and M&A to position for the future?
- What are the sources of capital that leadership is willing to tap?

> *For health systems located in the fastest-growing large metro areas, sheer volume growth will permit you to ride the old fee-for-service business model a bit longer. But that strategy's success will be measured in years rather than decades.*

TGI thanks Dave Morlock, Managing Director, Head of Health Systems Group, Cain Brothers, for contributing this article. He can be reached at dmorlock@cainbrothers.com.

Grounding the Board...

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We kick off every board meeting with a "Mission Moment" bringing in groups from across the organization to talk about significant care challenges, patient experiences, or outcomes. Our board recently heard from an OB-GYN office about how it accommodated care for a group of several expecting refugee moms through language services and thoughtful cultural considerations. At another meeting, a multidisciplinary team shared an initiative to make regular cancer screenings more fun and less scary, repositioning an annual mammogram as a "Glammogram." Sharing these stories underscores the tangible outcomes of the board's decisions and investments. Celebrating milestones and recognizing the contributions of staff further reinforces a shared sense of accomplishment and pride in the organization's mission-driven work.

For board members to effectively fulfill their duties, it is essential that they have a deep and meaningful connection with the day-to-day operations and mission of the organization. Over time, we have evolved our approach, as I have heard feedback that being grounded in the mission and the work of the organization helps them make more informed decisions and drive meaningful change. And while we spend time ensuring our board has the appropriate understanding and expertise on the "business" side of healthcare, we find that bringing it back to the people—our patients, staff, and community—always serves us best. Ultimately, when board members are deeply connected to the work and mission of the organization, they can more effectively fulfill their responsibilities and contribute to the long-term success and sustainability of our healthcare system.

TGI thanks Kathleen Silard, M.S., B.S.N., RN, FACHE, President and CEO of Stamford Health, for contributing this article. She can be reached at ksilard@stamhealth.org.

"Starting each board meeting with a 'Mission Moment' helps ground us in the work we are supporting. Hearing from staff across the organization highlights how they all have a fingerprint on the work of Stamford Health and reminds me that for every story we hear, there are countless others that happen quietly, in service of our mission every day."
—James Thomas, Board Chair

Fear Not the Executive Session

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Feedback from the board is a gift. No CEO is perfect—every CEO has opportunities for growth, development, and improvement. Few people are in as good a position to give CEOs that feedback as the board. The CEO's goal as a leader should be continuous improvement for themselves as well as the organization they are leading. Strong boards have always made me a better CEO.

Having time for the board to provide feedback on a regular basis also ensures that there are no surprises. CEOs should never be blindsided by a poor annual evaluation or an unexpected difficult conversation as to whether the CEO will continue in their role. Being present anytime the board is in session is not going to stop board members from having concerns. Even though it may be painful to hear, I have always wanted to hear concerns or suggestions for improvement as soon as possible, so that I have a chance to course correct. Further, the board often has great recommendations.

Conclusion

I still get regular feedback from my wife about my performance after 44 years of marriage. That is probably why we are still married after all this time. CEOs shouldn't fear feedback or suggestions and boards need to feel comfortable voicing any doubts or frustrations.

Board chairs also have an important role in this. CEOs need to build trust with their board chairs and vice versa. I never feared being excused from a board executive session because I trusted my board chair to talk to me afterwards and let me know if any concerns or suggestions came up—nine times out of 10 they didn't.

TGI thanks David C. Pate, M.D., J.D., for contributing this article. Dr. Pate retired as President and CEO of St. Luke's Health System (Idaho) in 2020. He is currently chairman of the board of trustees for the Idaho College of Osteopathic Medicine. He can be reached at davidcpatemd@gmail.com.

A Strong Board–Executive Partnership...

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For example, one health system had articulated a 2030 vision wherein it would excel in quality and patient experience. This organization performed in the lowest quartile nationally and had set targets to very slowly inch its way up to the median. The board should challenge management to identify what excelling in quality means, the changes required to reach top-quartile or top-decile performance, potential risks of setting the bar high, investments needed, and risks of *not* improving.

Since no organization can change everything simultaneously, the board and executive team should agree on a "vital few" priorities that require bolder goals and outline the "who, how, when, and what (expected outcomes)" for each. Additionally, the workplans should incorporate contingency plans and short-term milestones that will allow the board and management to mitigate risks by monitoring ongoing progress and implementing corrective actions early.

Create a culture of safety around strategic implementation.

Pursuing bolder goals increases the likelihood of something going wrong, whether minor or catastrophic. Has the board created a culture of safety around strategic implementation, recognizing that despite well-laid plans, things may go off course? Does the management team feel safe sharing bad news with the board or does the board, perhaps unintentionally, discourage management from even attempting to achieve riskier, bolder goals?

Ensure that the executive compensation plan supports achieving bolder goals.

Most organizations have adopted executive compensation plans that include bonuses for the executive team based upon achievement of annual targets set by the board. The annual incentive compensation plan must be tied directly to the longer-term objectives in your strategic plan.

If you do not already do so, ensure that the incentive plan rewards not only achievement of incremental performance improvements but also progress against bolder goals. While many plans incorporate "stretch targets," often it is far better for the organization to have achieved a portion of a bolder goal than to have exceeded a relatively low-bar stretch performance target.

Conclusion

The cornerstone of a strong board–executive working relationship is trust. When your organization needs to actively pursue bolder goals, trusting your partner is especially essential. Trusting the executive does not mean that the board serves as a rubber stamp, passively accepting all of management's recommendations. Instead, both parties should understand their unique and complementary roles in setting strategic direction, be aligned around their willingness to accept and manage strategic risks, accept their responsibilities and accountability for strategic successes as well as setbacks, and stay in their own lane.

TGI thanks Marian C. Jennings, M.B.A., President, M. Jennings Consulting, and Governance Institute Advisor, for contributing this article. She can be reached at mjennings@mjenningsconsulting.com.

> *It is critically important that the board's and executive team's culture and risk preferences align, and match the overall strategic direction.*

A Strong Board–Executive Partnership Can Achieve Bolder Goals

By Marian C. Jennings, M.B.A., M. Jennings Consulting

How aspirational are your organization's mission and vision statements? Do they call for improving the health of the communities you serve, being the health system of choice for area residents, reimagining healthcare, and/or providing exceptional quality? In a rapidly changing environment, these aspirations cannot be achieved by incremental improvements alone. Instead, they require bolder, innovative transformation—actions that intrinsically are more overtly risky.

Meanwhile, does it seem that each year your organization focuses primarily on slow, incremental progress, centered on financial performance and quality? If so, it may be time to revisit how the board–executive relationship is enhancing or hindering achievement of bolder goals—goals that, while riskier, hold the potential to fundamentally improve strategic positioning, quality, and long-term financial viability.

It may be time to revisit how the board–executive relationship is enhancing or hindering achievement of bolder goals—goals that, while riskier, hold the potential to fundamentally improve strategic positioning, quality, and long-term financial viability.

Two conditions enable an organization to achieve bolder vision-driven goals: first, a competent, effective chief executive and his/her team and second, a strong relationship between the board and executive built upon trust, mutual respect, and open communication.

This article focuses on enhancing the board's ability and willingness to pursue bolder goals by strengthening its strategic alignment with the executive team.

Tips to Support Bolder Goal Setting and Achievement

Align board and management culture, risk tolerance, and risk appetite.

"Culture eats strategy for breakfast" is an adage often attributed to management guru Peter Drucker. It is critically important that the board's and executive team's culture and risk preferences align, and match the overall strategic direction. Consider:

- How much risk does your board prefer (its "risk tolerance")? Is your board's culture one that regularly selects initiatives with little chance of failing or causing disruption? If so, management may default to recommending a limited set of low-risk options to the board, perhaps unintentionally precluding the board from considering bolder approaches.
- How much risk is your board prepared to accept in pursuit of the organization's mission, vision, and strategic objectives (its "risk appetite")? What is management's risk appetite? How aligned are the two? Achieving bolder goals requires that the board and executive team be aligned on and willing to accept some degree of prudent risk.

Hospitals and health systems are unlikely to achieve an audacious vision without an aligned board and executive team willing to assume some risks, properly resource bolder long-term initiatives, and effectively manage strategic, financial, and reputational risks.

Build a common worldview with the executive team.

Although it may be tempting to skip, this step underpins a strong board–executive partnership and effective plan development and implementation.

All strategy builds on assumptions about the future. Does your board have a worldview and, if so, does it match that of management? Devote time with your leadership team to define together what you expect the healthcare landscape to be in five years and, more importantly, to agree on the implications for your organization. What will the market require your organization to be doing more of or very differently? What would be the greatest threats to achieving the hospital's stated mission and vision?

As part of this exercise, identify "wild cards" that could essentially upend your market, as well as what would be required to remain viable should any of those occur.

Unflinchingly and collaboratively identify major strategic gaps.

Building upon a common worldview, candidly assess where your organization needs fundamental change and innovation to address a strategic gap.

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››› KEY BOARD TAKEAWAYS

- Recognize that an aspirational mission and/or vision cannot be achieved by incremental improvements alone.
- Align your board's and executive team's culture and risk preferences and ensure that these are congruent with your overall strategic aspirations.
- Commonly identify the "vital few" strategic priorities that require bolder goals and utilize workplans with milestones and contingency plans to mitigate implementation risks.
- Identify where and how the board may be unintentionally discouraging management from recommending bolder goals for board consideration, including but not limited to the executive incentive compensation plan.